

Call 9-911 for: loss of consciousness, stroke, seizures, heart attack, electric shock, allergic reaction or bleeding and Call EHS @ 304-293-3792 to report.

For EH&S use only

Reclassified ____

____ Privacy Case ____ Needlestick ____ Body Fluids ____ Animal Bite
____ Asbestos ____ Chemical Spill ____ Pharmaceutical/Biohazard
WVU Occupational Medicine Health Care Evaluation Recommended
Describe on page 2 reason for Evaluation

Serious Injury (Notify within 24 hrs. for hospitalization)
Fatality ____ (Notify within 8 hrs.)
Near Miss ____ Exposure ____

SECTION ONE:

1. Name of Injured: _____ 2. WVU ID No. (700 xx xxxx): _____
(Last Name, First Name) (Middle) **WVU ID Number REQUIRED to process incident**
3. Gender: ____ Female ____ Male 4. Date of Birth: _____ or Age ____ 5. Date of Incident: _____
6. Time of Incident: _____ AM _____ PM ____ during work ____ entering work ____ leaving work ____ lunch/break
7. Campus: ____ Main ____ Potomac ____ WVUIT 8. Department: _____ 9. Job Title: _____
10. Employment Category: (Check one) ____ Faculty ____ Staff ____ Student Employee ____ Research Corp ____ Health Sciences
11. Status: ____ Fulltime ____ Part-time ____ Temporary
12. Length of Employment: ____ years 13. Time in occupation when incident occurred: ____ years
14. Describe Exactly what happened, Include timeline of event and OBJECT or SUBSTANCE that caused harm: *An example would be: slipped on wet floor, exposure to cleaning chemicals, cut with carpet knife. (For informational purposes, please submit detailed information on the attached "Incident Description Statement Form").*
15. Location of Incident include building and room number, state if outdoors : i.e. Engineering Sciences Bldg., Room G38
16. Describe the INJURY or ILLNESS and Specific BODY PART(S) affected: (An example would be: cut on palm of left hand or sprained lower back)

Exposure -EHS must receive a completed copy of the "Employee Injury/Incident Report" within 24 hours of the exposure.

SECTION TWO:

17. Was the victim wearing Personal Protective Equipment? (please specify) _____
18. Was the employee seen by a physician: ____ Yes ____ No 19. Name of Physician: _____
20. Location of Treatment: _____
21. Was employee in Emergency room? ____ Yes ____ No 22. Was employee hospitalized overnight as a patient? ____ Yes ____ No
23. Type of Treatment received: (check type)
- ____ Set Fracture/broken bone ____ Treat Infection ____ Stitches/Sutures ____ Tetanus Shot ____ Surgery
____ Prescription ____ Physical Therapy (more than once) ____ Remove foreign Object from eye
____ Hearing Loss ____ Does this issue need reviewed for ADA Concerns ____ Other-explain on back of form

Needlestick or Body Fluids – please report to local emergency room immediately (Ruby hospital after 4:30 p.m.

and call Occupational Medicine at 304.293.3693 for follow up) See link to CDC guidelines for Sharps injury treatment at <http://www.cdc.gov/niosh/stopsticks/whattodo.html>

SECTION THREE:

24. Total lost work days after the day of incident _____ 25. Total days of restricted activity _____
26. If employee has not returned to work check here _____
27. Does employee wish to file a Worker Compensation Claim? ____ Yes ____ No

Employee's Signature _____ Print _____ Ph. Number _____ Date _____
Supervisor Signature _____ Print _____ Ph. Number _____ Date _____

Complete form and immediately email to: WVUI InjuryIncidentReport@mail.wvu.edu (preferred) or fax to EHS (304) 293-7257, or mail Environmental Health and Safety Injury/Incident, PO Box 6551, Morgantown, WV 26506.

WVU EHS Employee Injury/Incident Form Rev 5. 5. 2023

PLEASE PROVIDE ONLY THE INFORMATION THAT IS REQUESTED ON THIS FORM

